

Religion as a Controlling Influence in Medical Decision Making by Mature(?) Minors

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INTRODUCTION

In January 2015 the national press reported the story of seventeen-year-old Cassandra C. who, with her mother, refused the chemotherapy recommended to treat her Hodgkin's lymphoma.¹ A trial court in Connecticut ordered Cassandra to undergo the treatment estimated to give her an eighty to eighty-five percent chance of survival.² She initially began treatment, but then ran away. The Supreme Court of Connecticut ultimately issued a two-page order³ upholding the trial court's decision to mandate treatment in an effort to preserve Cassandra's life.

Although Cassandra and her mother did not assert religious objections to the treatment,⁴ the case provides a very recent representation of the ongoing debate as to whether certain adolescents ought to have the right to make medical decisions for themselves.⁵ As the media attention surrounding Cassandra suggests,⁶ this issue becomes more complicated when the adolescent's

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¹ Sydney Lupkin, *Conn. Supreme Court Rule 17-Year-Old Cancer Patient Must Have Chemo*, ABC NEWS (Jan. 8, 2015), <http://abcnews.go.com/Health/conn-supreme-court-rules-17-year-cancer-patient/story?id=28093594>.

² Josh Kovner, *Connecticut Supreme Court Upholds Ruling That State Can Force Chemotherapy on Teen*, HARTFORD COURANT (Jan. 8, 2015), <http://www.courant.com/news/connecticut/hc-teen-battles-chemo-order-0103-20150102-story.html?dssReturn&z=39110#page=1>.

³ See <http://jud.ct.gov/external/news/press404.pdf>.

⁴ Instead, both maintained that the treatment was a toxin worse than the cancer itself. Kovner, *supra* note 2.

⁵ See e.g., Jessie Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL'Y 37 (2012); Kimberly M. Mutcherson, *Whose Body is it Anyway? An Updated Model of Healthcare Decision-making Rights for Adolescents*, 14 CORNELL J. L. & PUB. POL'Y 251 (2006); Jennifer L. Rosato, *The End of Adolescence: Let's Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decision-Making*, 51 DEPAUL L. REV. 769 (2002); Rhonda Gay Hartman, *Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices*, 8 U. CHI. L. SCH. ROUNDTABLE 87 (2001).

⁶ See, e.g., *Connecticut Supreme Court Upholds Ruling that Teen Must Undergo Chemo*, FOX NEWS (Jan. 8 2015) http://www.foxnews.com/health/2015/01/08/connecticut-supreme-court-upholds-ruling-that-teen-must-undergo-chemo/?cmpid=cmt_twitter_fn (reporting a legal analyst's views that the Connecticut Supreme Court decision was right on the law, right on the ethics, and right on humanity). *But see, Cassandra's Catch-22*, THE ECONOMIST (Jan. 14, 2015) <http://www.economist.com/blogs/democracyinamerica/2015/01/medical-consent> (reaching the opposite conclusion and expressing concern about the violation of Cassandra's liberty and the rights of her mother). Even well-known bioethicist Arthur Caplan weighed in on the situation. Arthur Caplan, *Bioethicist: Why Connecticut Teen Can't Say No to Chemo*, NBC NEWS (Jan. 8, 2015) <http://www.nbcnews.com/health/cancer/bioethicist-why-connecticut-teen-cant-say-no-chemo-n281836> (agreeing with the decision to force Cassandra to undergo treatment, although at least implying that if Cassandra had a religious motivation, that might alter his opinion).

refusal of treatment would lead to her death.⁷ And as I have suggested elsewhere, the complexity is only heightened when the adolescent's decision is based on religious beliefs.⁸

In the context of adolescent refusal of life-saving medical treatment,⁹ these issues arise because of several general aspects of the law. First is the legal presumption that those over the age of eighteen may make decisions for themselves, while those seventeen and under may not.¹⁰ Second, parents have a constitutional right to make decisions on behalf of their minor children.¹¹ Third, this parental right is not unlimited; parents are not permitted to imperil the lives of their children.¹² Finally, when confronted with the situation where a parent may not refuse life-saving medical treatment on behalf of the child, families have asserted that the decision is being made by a minor who is mature enough to have her own decision respected.¹³

As the title suggests, this paper expands on my earlier work by focusing on how religion might serve as a controlling interference that prevents autonomous choice by the adolescent purporting to make the medical decision.¹⁴ Part I provides a brief background on how medical decisions

⁷ See e.g., Christophe Lemmens, *End-of-Life Decisions and Minors: Do Minors Have the Right to Refuse Life Preserving Medical Treatment? A Comparative Study*, 28 MED. & L. 479 (2009); Ann Eileen Driggs, Note, *The Mature Minor Doctrine: Do Adolescents Have the Right to Die?*, 11 HEALTH MATRIX 687 (2001); Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J. L. MED. & ETHICS 109 (2000).

⁸ Jonathan F. Will, *My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based Upon Religious Beliefs*, 22 J. CONT. HEALTH L. & POL'Y 233 (2006). See also Jennifer E. Chen, Note, *Family Conflicts: The Role of Religion in Refusing Medical Treatment for Minors*, 58 HASTINGS L. J. 643 (2007).

⁹ Life-saving medical treatment stands in contrast to life-sustaining treatment. Martin T. Harvey, *Adolescent Competency and the Refusal of Medical Treatment*, 13 HEALTH MATRIX 297, 316 (2003). The former refers to treatment that will ensure the patient's survival in emergent circumstances. Blood transfusions are considered here to be life-saving, because they are often given (even in the context of cancer treatment) to stave off certain death. For instance, chemotherapy may lead to severe anemia requiring an immediate blood transfusion. See Rita Swan, *Boy Dies After Refusing Blood*, CHILD, INC., 1 (2007), available at <http://childrenshealthcare.org/wp-content/uploads/2010/10/2007-04-fnl.pdf> (describing the treatment regimen facing fourteen-year-old Dennis Lindberg in his battle with leukemia). The blood transfusion is life-saving, whereas chemotherapy itself is more accurately categorized as life-sustaining in that the chemotherapy is prolonged treatment that may offer the hope of maintaining the patient's life for an extended period (perhaps months or years), but also carries with it a qualitative assessment of the harm associated with the prolonged treatment. Jehovah's Witnesses will agree to the chemotherapy, but will refuse blood transfusions, making the distinction particularly important in that context.

¹⁰ Hartman, *supra* note 5, at 88. For discussion of the exceptions to this rule in the context of minors see *infra* Part I.

¹¹ *Troxel v. Granville*, 530 U.S. 57, 65-66 (2000).

¹² *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944) (stating that "parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."). See Will, *supra* note 8, at 251-254 (discussing cases struggling to determine when religious refusals amount to *Prince*-like martyrdom).

¹³ See Will, *supra* note 8, at 259-283 (evaluating several cases involving the so-called Mature Minor Doctrine). For further discussion see *infra* Part II.

¹⁴ Given that "fully autonomous" action is an unrealistic ideal, the concept of autonomy used in the context of medical decision making is more akin to what Ruth Faden and Tom Beauchamp describe as "substantially

are typically made on behalf of and by minors (and why). Part II describes the mature minor doctrine and the ethics of medical decision-making. Part III then offers examples of minors refusing life-saving treatment based on asserted religious beliefs. It also suggests that there is the potential that these minors are unduly influenced by family or religious leaders (or both), and that the current legal landscape inadequately addresses these concerns. Finally, Part IV offers a path forward in assessing the voluntariness of religious refusals made by minors.

I do not suggest that all minors asserting religious objections ought to be forced to receive treatment against their expressed wishes. Indeed, the mature minor doctrine serves a valuable role in respecting the autonomy of certain adolescents. I conclude, however, that the presumption that those under the age of eighteen are incompetent should be preserved. And where states permit minors to rebut this presumption, health care professionals and the state itself must be vigilant in determining whether the minor's choice reflects a decision made free from controlling interference. It just so happens that this concern is often amplified in the context of religious refusals.¹⁵

I. THE LAW OF MEDICAL DECISION-MAKING ON BEHALF OF AND BY MINORS

Sometimes out of sheer practical necessity bright lines must be drawn in the law. Setting the age of majority at eighteen, after which individuals achieve adult status and are vested with the ability to make their own decisions, is one such example.¹⁶ It would not be feasible for a full-blown competency inquiry to be performed every time a decision needs to be made, so we presume that those eighteen and older possess the education and informed understanding necessary to make decisions for themselves.¹⁷

But as the Supreme Court of the United States has held, those seventeen and under are presumed to lack the “maturity, experience, and capacity for judgment required to make life’s difficult decisions.”¹⁸ The Court elaborated that “most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment.”¹⁹

autonomous action,” pursuant to which sufficiently informed decisions may be respected even if falling short of fully autonomous action. RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 237-41 (1986).

¹⁵ This analysis could be applied to adults refusing treatment based on religious beliefs as well, but that is beyond the scope of this project. Adults are presumed competent, and the burden would be on the one challenging competence to establish that the adult in question should not be permitted to refuse the treatment. If a medical professional thought that an adult was being unduly influenced, perhaps a competency inquiry should be pursued. But the exact opposite presumption applies to minors. Minors are presumed incompetent, and the burden is on them to establish their capacity to make medical decisions. Part of that analysis must involve determining whether the minor's decision is being unduly influenced by third parties.

¹⁶ Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 *HOFSTRA L. REV.* 547, 558-559 (2000).

¹⁷ *Id.* at 562.

¹⁸ *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

¹⁹ *Id.* at 603. Of course, the mature minor doctrine calls this presumption into question. See *infra* Part II.

Instead, in most circumstances the law empowers parents or guardians to make these decisions on behalf of minors. The justification for this framework “rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment,” and that “natural bonds of affection lead parents to act in the best interests of their children.”²⁰ Ethicists agree.

In their book *Deciding for Others: The Ethics of Surrogate Decision Making*, Allen Buchanan and Dan Brock note the legal right of parents to raise their children as they deem appropriate, but they also suggest other important reasons why parents should be permitted to make medical decisions for their children: (1) in most circumstances parents are in the best position to make these decisions because they both know their children and care for them more than others; (2) parents must share (along with the child) in the consequences of the decision made; and (3) the family is a valuable social institution that must operate free from “oversight, control, and intrusion.”²¹ Lainie Friedman Ross writes of the family itself as an autonomous unit, with the parents in the best position to further familial goals and purposes.²²

Although parents are given wide latitude to make medical decisions on behalf of their minor children, there are exceptions. As indicated, parents are not permitted to make decisions that will imperil the lives of their children. While parents may refuse a life-saving blood transfusion for themselves, they are not permitted to refuse the same for their children.²³ In such a case the parents are thought not to be protecting the interests of the child, so the State steps in as *parens patriae*²⁴ to order the treatment.

But situations do exist where minors are permitted to make medical decisions for themselves. Putting the mature minor doctrine to one side,²⁵ these situations fall into three categories: (1) status exceptions, (2) treatment exceptions,²⁶ and (3) abortion.²⁷ The various states have taken different approaches to status and treatment exceptions, but for purposes here it is sufficient to identify examples where minors have been granted medical decision-making authority.

Status exceptions (which actually extend authority beyond medical decision-making) are typically tied to individual or social circumstances such as minors graduating from high school,

²⁰ *Id.* at 602.

²¹ ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 233-34 (1989).

²² LAINIE FRIEDMAN ROSS, *CHILDREN, FAMILIES AND HEALTH CARE DECISION-MAKING* 62 (1998).

²³ Walter Wadlington, *Medical Decision Making for and by Children: Tensions Between Parent, State, and Child*, 1994 U. ILL. LAW. REV. 311, 315 (1994). See also Will, *supra* note 8, at 251-254. The refusals dealt with in the present paper all imperil the lives of the minors in question.

²⁴ *Prince v. Massachusetts*, 321 U.S. 158, 167 (1944) (describing the State’s role in this regard). The State of Connecticut exercised this power in the case of *Cassandra C.* See *supra* notes 1-2 and accompanying text.

²⁵ See discussion of mature minor doctrine *infra* Part II.

²⁶ See e.g., Mutcherson, *supra* note 5, at 264-268 and Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Decision-Making*, 28 AM. J. L. & MED. 409, 421-22 (2002) (each describing various state statutes permitting minors to make medical decisions for themselves).

²⁷ See e.g., *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976); *Bellotti v. Baird*, 443 U.S. 622 (1979); *Lambert v. Wicklund*, 520 U.S. 292 (1997). I list abortion separately to avoid classifying “pregnancy” as a status or “abortion” as a treatment.

getting married, joining the armed services, or having children of their own.²⁸ Treatment exceptions exist to allow minors to receive treatment for certain conditions without getting approval from their parents. Examples include treatment for sexually transmitted infections, alcohol or drug dependency, and physical or sexual abuse.²⁹ Notably, these status and treatment exceptions do not necessarily involve any sort of determination that the minors in question possess a greater level of maturity than their adolescent counterparts.³⁰ Jennifer Rosato indicates that “these exceptions appear to exist because of an ease of application and need for consistency, rather than a recognition of the minor’s autonomy.”³¹

The ability of minors to choose to undergo an abortion hovers on the line between the previously mentioned exceptions and the mature minor doctrine (discussed below). In 1976 the Supreme Court held that minors cannot be required to obtain parental consent before accessing abortion services.³² The Court felt that the privacy right of the child outweighed any independent interest of the parent.³³ Three years later the Court determined that a state may impose a parental consent requirement so long as the minor has the ability to seek a judicial bypass.³⁴

Such bypass gives the minor the ability to show either that she is mature enough to make the decision for herself or, regardless of her maturity, that that abortion would be in her best interest.³⁵ Although the Supreme Court has never extended this judicial bypass mechanism to other areas of medical decision-making, it at least reflects a willingness to entertain an assessment of the decision-making capacity of those under the age of majority. Through the mature minor doctrine, some states of have taken up this mantle.

II. THE MATURE MINOR DOCTRINE AND THE ETHICS OF MEDICAL DECISION-MAKING

The mature minor doctrine is founded on the premise that certain minors possess the requisite capacity to make autonomous decisions deserving of respect as such.³⁶ It serves to counter blind reliance on bright line rules and presumptions. Those in support of the doctrine³⁷ point to studies

²⁸ Mutcherson and Hartman, *supra* note 26.

²⁹ *Id.*

³⁰ Hartman, *supra* note 26, at 422.

³¹ Will, *supra* note 8, at 256 (citing Rosato, *supra* note 5, at 777).

³² *Planned Parenthood v. Danforth*, 428 U.S. 52, 75 (1976).

³³ *Id.*

³⁴ *Bellotti v. Baird*, 443 U.S. 622, 643 (1979)

³⁵ *Id.* at 643-644.

³⁶ Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L. J. 1265, 1270-1271 (arguing that “autonomous decisional ability should be the cornerstone for a coherent legal model governing issues of adolescence.”)

³⁷ Though it exists primarily as a creature of common law, some states have adopted statutes granting decisional authority to adolescents under the age of eighteen. See Will, *supra* note 8, at 259-262.

performed beginning in the late 1970s and early 1980s after the Supreme Court recognized the potential decision-making authority of pregnant teens.³⁸

These studies indicate that the competence of at least certain older adolescents is on par with young adults.³⁹ Indeed, one study exploring medical treatment decisions found that minors aged fourteen and older “demonstrate a level of competency equivalent to that of adults.”⁴⁰ Such minors would no longer need the protection of their parents or the State in making medical decisions. But it would be a mistake to generalize.

Thomas Grisso and Linda Vierling determined in one of the earliest studies that “it would be inaccurate to conclude that all adolescents are intellectually capable of providing independent consent.”⁴¹ And David Scherer highlighted a “specific concern about the degree of parental influence acting as a coercive force” that would negate the voluntariness of the minor’s decision.⁴² This suggests that even if a fourteen or fifteen-year-old possesses the cortical structures necessary for making informed decisions, it does not mean that they are able to do so. Any assessment would necessarily be context specific.

Of course, states adopting the mature minor doctrine typically do not eliminate the presumption of incompetence; rather, they create a framework in which certain minors may rebut the presumption.⁴³ The Supreme Court of Tennessee provided one of the most oft-cited formulations of the standard for rebutting adolescent incompetence when it stated that:

whether a minor has the capacity to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved. Moreover, the totality of the circumstances, the nature of the treatment and its risks or probable consequences, and the minor’s ability to appreciate the risks and consequences are to be considered.⁴⁴

³⁸ *Id.* at 261 (citing Thomas Grisso & Linda Vierling, *Minors’ Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412, 421 (1978); Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982); David G. Scherer & N. Dickon Reppucci, *Adolescents’ Capacities to Provide Voluntary Informed Consent*, 12 LAW & HUM. BEHAV. 123 (1988); David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 LAW & HUM. BEHAV. 431 (1991). Jennifer Rosato notes that these studies have been criticized for utilizing a subject base that was predominantly white, middle-class, and that they defined competence too narrowly without taking into account psychosocial factors that might impact adolescents more than adults.

³⁹ Hartman, *supra* note 5, at 96-98.

⁴⁰ Weithorn & Campbell, *supra* note 38, at 1595 (supporting earlier work performed by Jean Piaget).

⁴¹ Grisso & Vierling, *supra* note 38, at 421 (1978). Rosato, *supra* note 5, at 785-786.

⁴² See Mutcherson, *supra* note 5 (citing to Scherer, *supra* note 38, at 434-35).

⁴³ Cf. Mutcherson, *supra* note 5, at 303 (arguing in favor of a presumption of competence for older adolescents).

⁴⁴ *Cardwell v. Bechtol*, 724 S.W. 2d 739, 748 (1987) (cited by e.g. *Commonwealth v. Nixon*, 761 A.2d 1151, 1154 (Pa. 2000); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 836 (W.Va. 1992); *In re E.G.*, 549 N.E.2d 322, 327 (Ill. 1989).

This language calls to mind the doctrine of informed consent. To put the mature minor doctrine in proper context then, it is necessary to briefly discuss the rise of informed consent and the ethics of medical decision-making.

The doctrine of informed consent reflects a paradigmatic shift in how medical decision-making takes place.⁴⁵ The Beneficence Model, which existed relatively unchanged for over 2,000 years, was categorized by trusting patients giving unfettered discretion to physicians. But today, under the Autonomy Model, patients are expected to play an active role in determining their course of treatment.⁴⁶

As a legal concept, informed consent took hold in the 1970s in connection with the larger bioethics movement. Philosophers were enlisted to sit on national commissions studying the treatment of human subjects, and they suggested that patients ought to be treated as autonomous agents.⁴⁷ Respecting patient autonomy is now a foundational bioethical principle premised on the notion that the self-determination of patients should be honored.⁴⁸

It is true that patients had been “consenting” (or at least assenting) to medical procedures for millennia, but respect for autonomy demands more. Beauchamp and Childress, while acknowledging degrees of autonomous authorization, speak of personal autonomy as encompassing, “at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as inadequate understanding that prevents meaningful choice.”⁴⁹ Inadequate understanding (ignorance) itself could be viewed as a controlling interference that prevents autonomous choice. The legal doctrine of informed consent is thus an acknowledgment that patients cannot exercise substantial autonomy unless they are given the information material to making an intelligent and meaningful choice – diagnosis, treatment options, risks attendant upon each (including the risk of nontreatment), and so forth.⁵⁰

To embrace patient autonomy is to accept that patients are owed respect “for their ability to make reasoned choices that are their own and that others may or may not share.”⁵¹ Indeed, physicians often do not share the beliefs of Jehovah’s Witnesses that lead the latter to refuse life-saving

⁴⁵ See e.g., Jonathan F. Will, *A Brief Historical and Theoretical Perspective on Patient Autonomy and Medical Decision Making, Part I: The Beneficence Model*, 139 CHEST 669 (2011); Jonathan F. Will, *A Brief Historical and Theoretical Perspective on Patient Autonomy and Medical Decision Making, Part II: The Autonomy Model*, 139 CHEST 1491 (2011) [hereinafter Will, *Autonomy Model*]. For a more comprehensive discussion, see generally FADEN & BEAUCHAMP, *supra* note 14.

⁴⁶ Will, *Autonomy Model*, *supra* note 45, at 1491-1492.

⁴⁷ *Id.* (citing to the Belmont Report issued in 1979 (available at <http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html>)) (last visited February 25, 2015).

⁴⁸ See, e.g., TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 99-140 (6th Ed. 2009). The authors acknowledge critiques of traditional views of autonomy, most notably by feminist scholars who emphasize notions of “relational autonomy,” but those critiques support rather discount the importance of ensuring that decisions are made free from the controlling interference of others. See also Mutcherson, *supra* note 5, at 273-74.

⁴⁹ BEAUCHAMP & CHILDRESS, *supra* note 48, at 99. See also, FADEN & BEAUCHAMP, *supra* note 43, at 8

⁵⁰ Will, *Autonomy Model*, *supra* note 45, at 1495-1496.

⁵¹ EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *THE VIRTUES IN MEDICAL PRACTICE* 21 (1993).

blood transfusions.⁵² But today⁵³ we acknowledge that, if given sufficient information, patients are in a better position to determine what “they believe will best promote their own well-being,” and that physical health is not the only value (or even the most important value) that is given consideration.⁵⁴

Of course, respecting patient autonomy is about more than legally sufficient disclosure and obtaining informed consent. It presupposes that the patient’s ultimate decision is made free from controlling interferences other than ignorance as well.⁵⁵ To be sure, no decision is made in a vacuum. Interference and influence are inevitable. But the decisions of autonomous agents are not controlled by third parties; they “are governed by a self-conception developed over time in relation to cultural and social experiences.”⁵⁶

Although the concepts are not identical, in practice, attributes of autonomous persons go hand in hand with standards of competence, with each featuring a certain level of cognitive skill and independence of judgment.⁵⁷ As mentioned, adults are presumed to possess the capacity necessary to make independent decisions in line with their self-conceived notion of well-being. Therefore, absent peculiar circumstances,⁵⁸ adults are vested with the authority to control their medical treatment. When minors seek to rebut their presumed incompetence, however, they have the burden to establish that the asserted decision is in line with their own self-conceived sense of well-being.

The cultural and social experiences through which minors develop such a self-conception are shaped (ethically and legally so) by their parents or guardians.⁵⁹ And these experiences include religious upbringing, which is considered “one of the core aspects of parenting.”⁶⁰ The Supreme Court has acknowledged the constitutional dimension of parents’ interest “with respect to the religious upbringing of their children.”⁶¹ Part III now explores adolescent refusal of life-saving

⁵² Jehovah’s Witnesses interpret several Biblical passages as forbidding the consumption of blood, which they view to include blood transfusions. See THE JEHOVAH’S WITNESS TRADITION: RELIGIOUS BELIEFS AND HEALTH CARE DECISIONS (Edwin R. Dubose et al. eds. 2001).

⁵³ *Compare* Application of the President and Directors of Georgetown College, 331 F.2d 1009 (D.C. Cir. 1964) (ordering treatment over objection of Jehovah’s Witness) *with* Public Health Trust of Date County v. Wons, 541 So.2d 96 (Fla. 1989) (holding that adult Jehovah’s Witness had the right to refuse).

⁵⁴ BUCHANAN & BROCK, *supra* note 21, at 30.

⁵⁵ FADEN & BEAUCHAMP, *supra* note 14, at 256.

⁵⁶ Will, *supra* note 8, at 242. Faden and Beauchamp avoid the word “voluntary” altogether, and speak in terms of actions that are noncontrolled. FADEN & BEAUCHAMP, *supra* note 14, at 258. For additional discussion see *infra* notes 92-95 and accompanying text.

⁵⁷ BEAUCHAMP & CHILDRESS, *supra* note 48, at 113-14.

⁵⁸ A patient’s disagreement with the physician’s recommended course of treatment may give rise to a competency inquiry, but not necessarily. See BUCHANAN & BROCK, *supra* note 21, at 58.

⁵⁹ See *infra* Part I.

⁶⁰ Emily Buss, *What Does Frieda Yoder Believe*, 2 U. PA. J. CONST. L. 53, 54 (1999).

⁶¹ *Wisconsin v. Yoder*, 406 U.S. 205, 214 (1971).

medical treatment based on the religious beliefs instilled by parents and religious leaders⁶² in the context of respecting patient autonomy.

III. RELIGIOUS REFUSALS, INFLUENCE, AND CAUSE FOR CONCERN

Dennis Lindberg

Dennis Lindberg was diagnosed in November 2007 with acute lymphocytic leukemia shortly after his fourteenth birthday. He began chemotherapy with an estimated seventy to seventy-five percent chance of survival, but both he and his legal guardian (a Jehovah's Witness)⁶³ refused the blood transfusions that became necessary to treat the severe anemia resulting from the chemo.⁶⁴ Without the blood transfusions his condition deteriorated rapidly rendering him unconscious.

For the reasons discussed in Part I, Dennis' guardian, who happened to be his aunt, could not refuse the blood transfusions for him. A Washington State judge, against the protestations of his parents (who had given up custody due to prior drug abuse), determined that Dennis was mature enough to make the decision for himself.⁶⁵ Without ever having spoken to Dennis, the judge stated that "I don't believe Dennis' decision is the result of any coercion. He is mature and understands the consequences of his decision."⁶⁶ Dennis died just three weeks after his initial diagnosis, and less than one year after being baptized into the Jehovah's Witness faith.⁶⁷

Of course the judge did hear testimony regarding Dennis' beliefs. His opinion indicated that "I don't think Dennis is trying to commit suicide. This isn't something Dennis just came upon, and he believes with the transfusion he would be unclean and unworthy."⁶⁸ Indeed, it is important not to discount the nature of these beliefs.

Some Jehovah's Witnesses compare forced blood transfusions to rape,⁶⁹ and that if they receive blood it will sever their relationship with the church and with God, thereby forfeiting a chance at

⁶² The problem of potentially undue influence is not limited to religious refusals. In the case of Cassandra C., some commentators expressed concern that the mother was in the "driver's seat." See Kovner, *supra* note 2. Although the Connecticut Supreme Court determined that Cassandra was not a mature minor, noticeably absent was any discussion of whether she was being impermissibly influenced by her mother. See <http://jud.ct.gov/external/news/press404.pdf>.

⁶³ Unlike Christian Scientists, Jehovah's Witnesses will agree to medical care (other than blood transfusions), so Dennis' case serves as a useful example. But the issues presented in this paper would be equally implicated where an older adolescent refused all medical care.

⁶⁴ Swan, *supra* note 9, at 1-2.

⁶⁵ *Boy Who Refused Blood Transfusion Dies*, CBS NEWS (Nov. 30, 2007), <http://www.cbsnews.com/news/boy-who-refused-blood-transfusion-dies/>.

⁶⁶ *Id.*.

⁶⁷ Swan, *supra* note 9, at 1.

⁶⁸ *Id.* at 3-4.

⁶⁹ In re E.G., 515 N.E.2d 286, 289 (Ill. App. Ct. 1987).

eternal life.⁷⁰ By refusing blood transfusions, a Jehovah's Witness is expressing a view that her sense of spiritual wellbeing is more important than physical wellbeing.⁷¹ Surely if autonomy is to be respected, we must honor such decisions regardless of whether we share the person's underlying beliefs.⁷² But such respect is only due where the patient is competent and was able to make the decision free from controlling interference.

While we presume both an adult's competence and ability to make decisions independently, even in states adopting the mature minor doctrine, such minors would have to prove it. I have suggested elsewhere that it would be a mistake in the context of religious refusals to limit the competency analysis to whether the minor can communicate, understand, and reason⁷³ regarding the medical aspects of the decision being made.⁷⁴ Refusing a blood transfusion is not overly complex. It would not require much to understand what the transfusion is for and what will happen if not administered.⁷⁵ The religious aspect is far more complicated, raising questions of biblical interpretation and capacities to comprehend corporal versus spiritual existence.

But my emphasis in this paper is on whether the minor's decision is sufficiently voluntary to be given controlling effect. This takes into account both the minor's general capacity to think independently, and the level of influence confronted in the given circumstance. Here again, Dennis' situation, though not unique,⁷⁶ helps to elucidate.

After years of turmoil with his birth parents, Dennis received love and stability in the home of his aunt. That included introduction to her chosen faith. It is not uncommon for parents or guardians to "impose a presumed religious identity upon a child without requiring the child's consent or understanding."⁷⁷ Then again, the risks associated with such religious indoctrination are generally very low.

But when Dennis became sick, the level of risk changed. To be sure, his aunt and the religious leaders surrounding his hospital bed felt that they were acting in his best spiritual interests. They argued that it was necessary to keep non-believers away from him so as not to test his faith.⁷⁸ The aunt described well-wishers from school, and even Dennis' grandmother's attempts to reach out to him, as "Satan's greatest test," and as his condition became more perilous, the religious

⁷⁰ See THE JEHOVAH'S WITNESS TRADITION, *supra* note 52 at 6.

⁷¹ PELLEGRINO & THOMASMA, *supra* note 51, at 58.

⁷² BEAUCHAMP & CHILDRESS, *supra* note 48, at 102.

⁷³ These are the capacities generally associated with competency assessments. *Id.* at 114-117.

⁷⁴ See Will, *supra* note 8, at 282-84.

⁷⁵ Compare this with a decision weighing the risks associated with surgical versus chemical treatment of a given disease while taking into account long-term survival, quality of life, cost and so forth.

⁷⁶ See *infra* notes 96-103 and accompanying text.

⁷⁷ *Zummo v. Zummo*, 574 A.2d 1130, 1148-1149 (Pa. Super. Ct. 1990).

⁷⁸ Swan, *supra* note 9, at 4-7.

circle tightened around him.⁷⁹ How, if at all, does this inform an assessment of Dennis' status as an autonomous agent whose independent decisions are deserving of respect as such?

⁷⁹ *Id.* at 7.

Religion and Independent Thinking

As an initial matter, it is important to acknowledge the broad legal protections offered to those asserting religious motivations in the area of Free Exercise jurisprudence.⁸⁰ Given the constitutional magnitude of protecting religious beliefs, courts have been hesitant to look behind those beliefs to determine whether impermissible harm is taking place. Marci Hamilton writes that such courts often feel “backed into a corner” when confronting First Amendment challenges.⁸¹ But the deference and/or sensitivity that judges give to religious beliefs should not obscure the role that the medical professionals and courts must play in this context, which is to determine whether the minor in question ought to be empowered to make the decision at hand.⁸²

Certain aspects of the Jehovah’s Witness faith are of particular import. Dr. Osamu Muramoto wrote a series of essays in the *Journal of Medical Ethics* outlining his concerns regarding the religion’s blood policy.⁸³ These concerns, while applicable regardless of age, are all the more relevant in the context of adolescent refusals.

The church’s governing body, the Watch Tower Bible and Tract Society (WTS), through its official magazine *The Watchtower*, admonishes adherents to “avoid independent thinking,” and instead to abide unquestioningly to the tenets of the faith prescribed by the governing body.⁸⁴ Muramoto writes that “free thought and decision-making are prohibited for JW’s,”⁸⁵ and he conveys the message of a former leader within the WTS who wrote that independent thinking is viewed as “sinful, an indication of disloyalty to God and his appointed ‘channel.’”⁸⁶ Entire websites exist where former members convey similar messages, and offer support to each other.⁸⁷

⁸⁰ See, generally MARCI A. HAMILTON, *GOD VS. THE GAVEL* (2005) (discussing numerous situations where religious adherents have been granted exceptions to laws based on their asserted religious beliefs, even where such exceptions result in harm to third parties). See also Madhavi Sunder, *Piercing the Veil*, 112 *Yale L. J.* 1399 (2003) (noting how religious beliefs have been asserted to further gender discrimination).

⁸¹ HAMILTON, *supra* note 78, at 26 (2005).

⁸² Juliet Guicon & Ian Mitchell, *Medical Emergencies in Children of Orthodox Jehovah’s Witness Families: Three Recent Legal Cases, Ethical Issues and Proposals for Management*, 11 *PAEDIATRIC CHILD HEALTH* 655, 655 (2006).

⁸³ Osamu Muramoto, *Bioethics of the Refusal of Blood by Jehovah’s Witnesses: Part 1. Should Bioethical Deliberation Consider Dissidents’ Views?*, 23 *J. MED. ETHICS* 223 (1998) [hereinafter *Muramoto Part 1*]; Osamu Muramoto, *Bioethics of the Refusal of Blood by Jehovah’s Witnesses: Part 2. A Novel Approach Based on Rational Non-Interventional Paternalism*, 24 *J. MED. ETHICS* 295 (1998) [hereinafter *Muramoto Part 2*]; Osamu Muramoto, *Bioethics of the Refusal of Blood by Jehovah’s Witnesses: Part 3. A Proposal for a Don’t Ask Don’t Tell Policy*, 25 *J. MED. ETHICS* 463 (1998) [hereinafter *Muramoto Part 3*].

⁸⁴ Muramoto, *Part 1, supra* note 83, at 225.

⁸⁵ *Id.* at 224.

⁸⁶ *Id.* at 225.

⁸⁷ See, e.g., *JW Struggle* (available at <http://www.jwstruggle.com/2014/01/ten-years-after-leaving-the-jehovahs-witness-religion/>) (last visited March 6, 2015); *Jehovah’s Witness Recovery* (available at <https://www.jehovahswitnessrecovery.com/>) (last visited March 6, 2015).

Sinful as it may be to adherents of the faith, independent thinking is a hallmark of autonomous agents. Adults may make an autonomous decision to join the organization (or remain within it) and submit to its authority⁸⁸ – thereby calling us to honor their subsequent decision to refuse blood transfusions. But children of the organization do not have that luxury.

Instead, they are brought up in an environment that is not conducive to developing their skills as independent thinkers. As Kimberly Mutcherson notes, “children come to develop capacities for decision-making and for exercising liberties through guidance and practice.”⁸⁹ Yet these children may be deprived of that practice. This is particularly troubling when coupled with the potentially coercive impact adults can have on children,⁹⁰ and the sometimes perilous consequences of submitting to that influence in the context of refusing medical treatment.

As discussed, for a decision to be deserving of respect as substantially autonomous it must be free from controlling interference. Dr. Muramoto describes situations where patients agreed to blood transfusions only to change their minds after confronting organizational pressure.⁹¹ But external influence is unavoidable and not itself problematic. Such influence comes in three basic flavors: persuasion, manipulation, and coercion.

Persuasion, in the sense of appeal to rational reasons, does not prevent autonomous authorization.⁹² Coercion, on the other hand, which exists where a party presents a credible threat of harm (physical or psychological) that forces another person to act in a way so as to avoid that harm,⁹³ is never permissible.

What is far less clear, is when manipulation becomes impermissible, where manipulation is defined broadly to encompass any influence that goes beyond persuasion, but falls short of coercion.⁹⁴ Influence becomes progressively less permissible where threats or manipulation are used to displace “a person’s self-directed course of action.”⁹⁵ The behavior of parents and/or religious leaders may not be coercive, yet it may be sufficiently manipulative, particularly given the vulnerable state of certain minors, so as to prevent a substantially autonomous decision. This could be true even where the minor otherwise possesses the capacity to understand the treatment decision in question.

⁸⁸ *But see*, Gila Stople, *Countenancing the Oppression of Women: How Liberals Tolerate Religious and Cultural Practices that Discriminate Against Women*, 12 COLUM. J. GENDER & L. 154, 186–88 (2003) (challenging the notion that women necessarily make a free choice to submit to or remain in oppressive circumstances).

⁸⁹ Mutcherson, *supra* note 5, at 289.

⁹⁰ *See supra* notes 41-42 and accompanying text.

⁹¹ Muramoto *Part 3*, *supra* note 83, at 465. Dr. Muramoto also questions the practice of physicians consulting directly with church officials, suggesting that the ultimate decision maker may not even be the patient. Muramoto *Part 2*, *supra* note 83, at 296.

⁹² FADEN & BEAUCHAMP, *supra* note 14, at 347.

⁹³ *Id.* at 339.

⁹⁴ *Id.* at 354.

⁹⁵ BEAUCHAMP & CHILDRESS, *supra* note 46, at 133.

For instance, penalties for disobeying WTS teachings are severe. Such individuals are disfellowshipped; they are “spiritually cut off from the congregation; the former spiritual ties [are] completely severed,” including with members of the person’s family.⁹⁶ Marci Hamilton recounts the feeling of former members that “the threat of being thrown out of [the organization] and shunned from them is one powerful enough [to keep victims of abuse silent when told to do so by the organization].”⁹⁷ Such loss of family and friends was described by one individual as a “fate worse than death.”⁹⁸

Recall Dennis, surrounded in his hospital room by church leaders, prevented from speaking with nonbelievers (including members of his own family). And these issues are not unique to Dennis Lindberg.⁹⁹ One man (now 66) referred to himself as a “brainwashed boy [who] acceded to what was his father’s will” when describing his own decision, at seventeen, to refuse a blood transfusion that led to the loss of his leg.¹⁰⁰

A fifteen-year-old girl (member name “loner099”) joined the site *Jehovah’s Witness Recovery* in March of 2014. She explained that her heart condition has required multiple surgeries, for which her mother refused blood transfusions, and she pleaded for guidance – “I don’t know what to think of this. I don’t even know why I am telling this, if it was just so I can finally say what’s on my mind or if I want someones [sic] opinion on this . . .”¹⁰¹ Another adolescent Jehovah’s Witness complained of “shunning, information control,¹⁰² behavior control, and brainwashing,” but he also reported that he began to think independently about his beliefs by the time he was sixteen or seventeen.¹⁰³ Whether such influence amounts to coercion (or impermissible manipulation) requires a subjective inquiry, which is discussed more fully below.

These anecdotes suggest that, while some adolescents may feel pressured into a decision, others seem capable of thinking (or at least attempting to think) more independently. The technological age allows greater access to information, and limits the ability of authority figures to control the messages received. Kent Greenawalt suggests that most sixteen-year-olds have developed

⁹⁶ Muramoto *Part 1*, *supra* note 83, at 224.

⁹⁷ HAMILTON, *supra* note 78, at 25 (internal citation omitted).

⁹⁸ Guicon & Mitchell, *supra* note 80, at 656.

⁹⁹ See Muramoto Part 3, *supra* note 83, at 465 (describing it as typical where “family members, friends, and congregational members gather around the patient and ‘watch over their shoulder’”).

¹⁰⁰ See

<https://www.jehovahswitnessrecovery.com/forum/viewtopic.php?f=18&t=22178&sid=9446019c7b5f7152428ea134a6e9b6cc>.

¹⁰¹ See

<https://www.jehovahswitnessrecovery.com/forum/viewtopic.php?f=18&t=19584&sid=9446019c7b5f7152428ea134a6e9b6cc>.

¹⁰² The issue of information control is itself problematic as it may amount to impermissible manipulation that prevents autonomous choice. FADEN & BEAUCHAMP, *supra* note 14, at 362-65. For instance, Guicon and Mitchell discuss a situation where WTS leaders minimized the seriousness of a child’s condition, and Muramoto notes that WTS leaders will provide information that exaggerates the harms associated with blood transfusions. Guicon & Mitchell, *supra* note 80, at 656; Muramoto *Part 1*, *supra* note 81, at 228.

¹⁰³ See <http://jwfacts.com/watchtower/experiences/sk8erboi.php> (last visited March 7, 2015).

independent thoughts about religion, but he acknowledges that the analysis should not focus on “most”; rather, the “critical question . . . is about teenagers whose parents are in groups that have unusual views about medical treatment.”¹⁰⁴

For instance, divorced parents with children who remain in the Jehovah’s Witness congregation speak of “deprogramming” them,¹⁰⁵ language often associated with those leaving cults.¹⁰⁶ This is not to suggest that the Jehovah’s Witness religion is a cult, or that adherents should never be permitted to refuse life-saving blood transfusions. Dr. Muramoto himself describes recent pronouncements by WTS declaring that its members “have free choice” in medical matters,¹⁰⁷ and cases have been reported in other countries where there has been “no hint that [the adolescent’s] convictions were forced upon her or her stance influenced by either parents or church elders.”¹⁰⁸ But the concerns regarding lack of independent thinking are real, and they demand attention. In studying the religious development of minors, Elizabeth Ozorak determined that it is important to “weigh the influences of the parents and their chosen religious organization (if any) against the more diverse influences of peers.”¹⁰⁹

Other commentators suggest that children living in deeply religious homes are “constrained not just by love and affection for [their] family but by a continuing relationship of dependency and the limited opportunity [they] have enjoyed to widen [their] horizons.”¹¹⁰ Buchanan and Brock write that if children do not truly believe that the decision is theirs to make, “they will not resist attempts by others to impose those others’ choices on them.”¹¹¹ Further, children (particularly those aged fifteen and younger) often “do not assert themselves well against authority figures.”¹¹² A minor’s expressed decision to refuse life-saving treatment should not be honored unless it was reached free from controlling interference from parents, religious leaders, or otherwise. And this determination requires a more demanding inquiry than simply taking the minor’s words at face value.

As a Jehovah’s Witness, Dennis Lindberg may well have been taught to avoid independent thinking. And given that adolescents are particularly susceptible to peer pressure,¹¹³ it suggests that he may not have been acting as maturely and independently as the judge held. In fairness,

¹⁰⁴ Kent Greenawalt, *Objections in Conscience to Medical Procedures: Does Religion Make a Difference*, 2006 U. ILL. L. REV. 799, 813-814, n.58 (2006).

¹⁰⁵ See <http://www.jwstruggle.com/2013/02/email-exchange-with-a-concerned-father/>.

¹⁰⁶ See generally Richard Delgado, *When Religious Exercise is Not Free: Deprogramming and the Constitutional Status of Coercively Induced Belief*, 37 VAND. L. REV. 1071, 1078–87 (1984).

¹⁰⁷ Though Muramoto himself is not convinced. Muramoto *Part 3*, *supra* note 81, at 463-65.

¹⁰⁸ Caroline Bridge, *Religious Beliefs and Teenage Refusal of Medical Treatment*, 62 MOD. L. REV. 585, 587 (1999).

¹⁰⁹ Elizabeth W. Ozorak, *Social and Cognitive Influences on the Development of Religious Beliefs and Commitment in Adolescence*, 28 J. SCI. STUD. RELIG. 448, 448 (1989).

¹¹⁰ Margaret Brazier & Caroline Bridge, *Coercion or Caring: Analysing Adolescent Autonomy*, in CHILDREN, MEDICINE AND THE LAW 486 (Michael Freeman, ed. 2005).

¹¹¹ BUCHANAN & BROCK, *supra* note 21, at 223.

¹¹² *Id.*

¹¹³ Rosato, *supra* note 5 at 786.

the judge was operating in the absence of well-established guidance for dealing with such situations. There are very few cases in the United States dealing with the mature minor doctrine, and far fewer in the context of religious refusals of life-saving medical treatment.¹¹⁴ Even taken together, they offer little insight.

An Undeveloped Body of Law

Philip Malcolm, although just seven weeks shy of his eighteenth birthday, made it easy for a trial judge in New York to order a blood transfusion against Philip's (and his step father's) asserted refusal.¹¹⁵ Philip described himself as a child, indicated that he was not encouraged to make this decision for himself, and even stated that if the court ordered the blood transfusion, it would not be his sin.¹¹⁶ Thus, without passing judgment on the mature minor doctrine itself, the judge held that Philip was not mature enough to make the decision.¹¹⁷ Other cases are not so simple.

Three levels of the judiciary in Illinois weighed in when Ernestine Gregory, aged seventeen years, six months, refused a life-saving blood transfusion. The trial court ordered the treatment, expressing concern (though without elaboration) that "outward appearances and expressed beliefs often do not reflect the individual's true wishes."¹¹⁸ The intermediate appellate court expressed deference to religion like that described by Professor Hamilton. It determined that Ernestine was mature (without mention of the concerns discussed above regarding undue influence), and emphasized the "paramount importance of religious freedom in the history of our nation."¹¹⁹ The Illinois Supreme Court officially adopted the mature minor doctrine, but its analysis focused almost exclusively on the medical aspect of the decision, intentionally avoiding the constitutional question of whether minors like Ernestine have a First Amendment right that would support her decision to refuse medical treatment.¹²⁰

The highest court in Illinois was able to avoid applying its standard to Ernestine herself (since she was eighteen by that time), but the court indicated that if Ernestine's mother had disagreed with her decision, it would have weighed against a finding of maturity.¹²¹ The emphasis on parental agreement is problematic for two reasons. First, if Ernestine is adjudged mature, she no longer needs the decision-making protection of her mother; and second, it is well settled that

¹¹⁴ See Will, *supra* note 8, at 263-283 (discussing less than a dozen relevant cases). Three more recent examples include Dennis Lindberg (2007), Daniel Houser (a 2009 case out of the Fifth Judicial District in Minnesota; Court File No. JV-09-068), and Cassandra C. (2015).

¹¹⁵ In the Matter of Long Island Jewish Medical Center, 557 N.Y.S.2d 239, 240 (N.Y. Sup. Ct. 1990).

¹¹⁶ *Id.* at 241-42.

¹¹⁷ *Id.* at 243.

¹¹⁸ In re E.G., 515 N.E.2d 286, 293 (Ill. App. Ct. 1988) (McNamara, J. dissenting).

¹¹⁹ *Id.* at 290.

¹²⁰ In re E.G., 549 N.E.2d 322, 327-28 (Ill. 1989).

¹²¹ *Id.* at 328.

Ernestine's mother could not make a martyr out of her daughter.¹²² Indeed, I have suggested that in the context of religious refusals parental agreement should raise red flags, not lower them.

Courts in Canada, where the age of consent is sixteen, have also handled such situations, and seem to be more sensitive to the issues raised in this discourse. In one case involving an adolescent's refusal of a blood transfusion, the court considered the behavior of those surrounding the patient, and determined that "the undue influence put [on the minor] in the last few weeks [took] away her ability to make an informed choice."¹²³ In another case the court determined that a thirteen-year-old Jehovah's Witness "was not capable of refusing consent because he was deeply influenced by his father, whom he always obeyed without question."¹²⁴

More recently, the Supreme Court of Canada heard a case involving a fourteen-year-old minor (AC) who refused blood transfusions. AC was evaluated by three psychiatrists who reported that she was "alert and cooperative . . . very well spoken," and that she had "no psychiatric illness at present," but it was the parents who testified that AC "treasures her relationship with God and does not want to jeopardize it."¹²⁵ A dissenting justice¹²⁶ felt that this psychiatric assessment sufficiently established AC's maturity and independence of thought.¹²⁷ For its part, the majority did not seem convinced that being alert, free from psychiatric illness, and with very devout, supportive parents necessarily equates to maturity or independence of thought.

Although AC denied being pressured by her parents,¹²⁸ the majority of Canada's high court expressed uncertainty as to how probing the psychiatric inquiry really was. The Court felt that where the refusal of treatment carries a high risk of death, "a careful and comprehensive evaluation of the maturity of the adolescent will necessarily have to be undertaken to determine whether his or her decision is a genuinely independent one."¹²⁹ While the Court did not announce a formulaic approach, it suggested that judges ought to consider "whether the adolescent's views are stable and a true reflection of his or her core values and beliefs" as well as "the potential impact of the adolescent's lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment."¹³⁰ This is a step in the right direction, and courts in the United States would be wise to follow a similar path.

¹²² See *supra* Part I.

¹²³ Guicon & Mitchell, *supra* note 80, at 657.

¹²⁴ Re Dueck, 171 D.L.R. (Sask. Q.B. 1999).

¹²⁵ A.C. v. Manitoba (Director of Child and Family), [2009] 2 S.C.R. 181, at par. 96 (Can. 2009).

¹²⁶ Because AC was treated during an emergency, and was over sixteen when the case reached the Canadian Supreme Court, the majority did not pass judgment on AC's maturity at the time the blood transfusion was administered. *Id.* at par. 120.

¹²⁷ *Id.* at par. 164 (Binnie, J. dissenting).

¹²⁸ *Id.* at par. 182 (Binnie, J. dissenting).

¹²⁹ *Id.* at par. 95.

¹³⁰ *Id.* at par. 96.

IV. IDENTIFYING NONCONTROLLED DECISIONS AND SUBSTANTIAL AUTONOMY: A PATH FORWARD

It will undoubtedly be difficult to determine whether a given minor's decision has been unduly influenced. Faden and Beauchamp, while admitting to no definitive criteria for making the assessment, speak of impermissible influences as those that render "an action less than substantially noncontrolled and therefore outside the territory of influences compatible with substantially autonomous acts."¹³¹ Perfect voluntariness is an unrealistic ideal, but the question is whether the minor's decision is "voluntary enough to be protected from paternalistic interferences."¹³²

Relying heavily on the work of Joel Feinberg, Buchanan and Brock suggest that those assessing the voluntariness with which a decision is made be mindful of coercion, duress, or even more subtle manipulation.¹³³ The task is to distinguish influences that are "compatible with substantial autonomy from influences that are not,"¹³⁴ and in many cases it will not be obvious; it will "require experienced judgment and extensive knowledge of the situation" and of the minor in question.¹³⁵ To that end, emergency situations would need to be handled differently than non-emergencies.

Where analysis cannot be performed due to emergent circumstances, life-saving treatment should be given to stabilize the minor even if the parents convey that the minor had previously expressed views regarding the refusal of treatment. Jehovah's Witness minors may carry cards refusing emergency blood transfusions, but such cards should be disregarded.

In non-emergent circumstances medical professionals should be vigilant in assessing whether the risk of undue influence is present. Because individuals respond differently to external stimuli, each situation demands careful analysis of the extent to which the minor is capable of resisting such influence and remaining sufficiently independent.¹³⁶ As with determining competency more generally, assessing the independence with which a decision is made "is in essence a commonsense judgment about the adequacy of the patient's decision-making abilities for the decision task at hand."¹³⁷

Those making the assessment should do so without giving deference to the religious nature of the decision, and without giving undue weight to the parents' agreement with the minor's purported decision. To avoid improper influence from the medical professionals themselves, a neutral party (psychiatrist, social worker, ethics consultant, etc.) should consult with the minor privately,

¹³¹ FADEN & BEAUCHAMP, *supra* note 14, at 259.

¹³² BUCHANAN & BROCK, *supra* note 21, at 43.

¹³³ *Id.* at 42-43.

¹³⁴ FADEN & BEAUCHAMP, *supra* note 14, at 337.

¹³⁵ *Id.* at 373.

¹³⁶ *Id.* at 360.

¹³⁷ BUCHANAN & BROCK, *supra* note 21, at 81-82.

in the absence of family members and religious leaders.¹³⁸ If the parents or religious leaders resist, judicial intervention may be necessary.

The consultant should be cognizant of the stressful nature of the situation, and that it is not sufficient to take the minors' words at face value. A single question "do you feel pressured" would not be sufficient, as the minor may not fully appreciate the forms in which undue influence might come. During the consultation or consultations (as necessary), minors should be given the opportunity to fully discuss how they came to their decision.

Consultants should be encouraged to identify any sources of stress and influence, and should be particularly aware of the family and religious dynamics. To protect against information manipulation, such as where the risks of the underlying condition are minimized, or the risks associated with treatment are exaggerated,¹³⁹ it may be appropriate to ask the minors what types of information they have been exposed to, and to clarify any inaccuracies. While such clarifications may persuade the minor by appeal to reason, consultants and medical professionals should be careful to avoid manipulation or coercion of their own.

Two questions remain: how voluntary does the given decision need to be; and how certain do the consultants (or judges if it comes to that) need to be in their assessment that a given minor's decision to refuse life-saving treatment was voluntary. It should be clear that no test for assessing voluntariness will be perfect, and those making assessments will never know for sure whether they got it right.

Borrowing from the context of competency assessments, we might say that the level of voluntariness necessary to make the decision rises with the risk associated with it.¹⁴⁰ On this account, a higher level of voluntariness would be required to refuse life-saving treatment (risk of death), as compared to consenting to a flu shot. Beauchamp and Childress counter that the level of risk is only relevant to the question of what evidentiary standard is applied.¹⁴¹

The difference is not semantic. Given that influence cannot be removed completely, the level of voluntariness we require speaks to what amount of influence may be exerted over the decision maker while remaining compatible with substantial autonomy. The higher the risk, the less influence we ought to permit when giving decision-making authorization to a minor.

An evidentiary standard, on the other hand, speaks to how confident we need to be in our voluntariness assessment, but the level of risk associated with the decision is still relevant.¹⁴²

¹³⁸ Muramoto *Part 2, supra* note 81, at 298.

¹³⁹ *See supra* note 102.

¹⁴⁰ BUCHANAN & BROCK, *supra* note 21, at 55.

¹⁴¹ BEAUCHAMP & CHILDRESS, *supra* note 46, at 117.

¹⁴² *Id.*.

The choice of evidentiary standard ultimately reflects an attempt to allocate the risk of error in the most defensible way possible. Where the risk of getting it wrong is death, we ought to impose the heightened, clear and convincing evidentiary standard so as “to adjust the risk of error to favor the less perilous result.”¹⁴³ This suggests that both a high level of voluntariness and a heightened evidentiary standard should be applied when minors seek to refuse life-saving medical treatment based on their asserted religious beliefs. This is consistent with states like Illinois that require clear and convincing evidence to establish a minor’s maturity more generally.¹⁴⁴

CONCLUSION

In situations where parents are not permitted to refuse life-saving medical treatment on behalf of their older children, the argument is sometimes made that it is, in fact, the minor’s own decision. Certain jurisdictions permit such minors to rebut the presumption of incompetence, which reflects the view that some minors have sufficient capacity to make autonomous decisions regarding their medical care. But the existing case law and literature pay insufficient attention to the extent to which minors may be impermissibly influenced when making the asserted.

Refusals of life-saving blood transfusions by Jehovah’s Witnesses were used in this paper as a vehicle to highlight the problem, but these issues are implicated in any situation where third parties serve as a controlling interference that prevents independent thinking by the minor purporting to make the medical decision.¹⁴⁵ There is no question that forcing individuals to undergo treatment against their asserted wishes is not ideal. Physicians report being troubled and apologizing when restraining an adolescent to administer blood transfusions.¹⁴⁶ It is also unfortunate that children would need to be separated from their parents in order to fully assess the independence of the decisions being made. But the alternative – allowing minors to die based on decisions that are not truly their own – seems even more so.

¹⁴³ Conservatorship of Wendland, 28 P.3d 151, 170 (Ca. 2001); see also *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 282-283 (1990) (both cases discuss the theory behind civil evidentiary standards in the context of determining the previously stated wishes of presently incompetent patients regarding the withdrawal of artificial nutrition and hydration). It is worth raising, though space prevents full exploration here, that imposition of this heightened standard, with its goal of erring on the side of preserving life, itself reflects a societal judgment regarding the merits of Jehovah’s Witness beliefs. After all, Witnesses would argue that the more perilous result is eternal damnation. Indeed, this supports the status quo with respect to the presumption of adult competence. Anyone challenging the competence of an adult bears the burden to prove by clear and convincing evidence that the adult is incompetent. See Will, *supra* note 8, at 244. This reflects a societal determination that violating a person’s autonomy is itself a perilous result (assuming the person is at least substantially autonomous). See *Cruzan*, 497 U.S. at 313 (Brennan J., dissenting). But this all flows from a presumption of competence that is inapplicable to minors.

¹⁴⁴ *In re E.G.*, 549 N.E.2d 322, 326-327 (1989).

¹⁴⁵ *Muramoto Part 2*, *supra* note 80, at 300.

¹⁴⁶ *Guicon & Mitchell*, *supra* note 80, at 658.